Northern Sierra Rural Health Network

June 26, 2002

Federal Communications Commission
Office of the Secretary
236 Massachusetts Ave, NE
Suite 110
Washington, DC 20002

RE: RURAL HEALTH CARE SUPPORT MECHANISM – WC DOCKET NO. 02-60 FILED ELECTRONICALLY

Northern Sierra Rural Health Network (NSRHN) is the largest user of Universal Service support for rural health care in California. Over the past two years, ten rural health care providers that are members of our telemedicine network have received over $255,000 to help support telemedicine access for patients in this remote, underserved region of northern California.

Our attached comments provide recommendations in the following areas:

- Eligibility of rural health care providers
- Definition of Rural
- Calculation of Discounted Services
- Streamlining the Application Process
- Competitive Bidding
- Support for Internet Use
- Telecommunications Partnerships
- Fraud and Abuse

Our experience as a network of rural health care providers that has successfully navigated the complex process that is currently in place provides us with a unique perspective on this program. The Rural Health Care Program has the potential to greatly impact the quality of health services available to patients who reside in the most isolated areas of our nation. We applaud the FCC's willingness to improve the Universal Service program so it meets its full potential for service to rural communities.

Sincerely,

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Comments on FCC Proposed Rulemaking
Rural Health Care Support Mechanism
WC Docket No. 02-60

Submitted by Northern Sierra Rural Health Network
Nevada City, CA

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BACKGROUND

Northern Sierra Rural Health Network (NSRHN) is the largest user of Universal Service support in California. We are often referred to as a successful example of how Universal Service funds can be used to support health services that would otherwise not be available to rural patients. During Year 2 of the Universal Service program, our telemedicine network received 91% of the Universal Service funds expended in California ($122,289) and in Year 3, we received 95% of the funds spent in California ($132,449). We anticipate receiving well over 95% of the funding for California in Year 4 of the program.

NSRHN is a non-profit, rural health network that represents over 40 rural health clinics, Federally Qualified Health Centers, rural hospitals, and public health departments in eight rural counties in northeastern California. With the support of a number of public and private agencies, we have helped develop telemedicine capacity in 25 rural health sites in our region. Ten (10) of these rural health providers are located in a region of California that does not have access to ISDN services. To enable these providers to participate in telemedicine, we developed and now manage a complex telecommunications network consisting of three (3) channelized T-1 lines and three (3) PRI lines, connected to a video conferencing bridge to provide the "equivalent" of ISDN service for these ten health care providers.

The monthly line charges range from $937 to $1,542 per site, for a total monthly charge of $11,612 for the network. Universal Service pays for 89% of the cost of the line charges. The ten rural health care providers each pay $200 per month to pay for the balance of the line charges, and to help

pay for the taxes, fees, licenses, and usage costs that are not covered by Universal Service. With Universal Service, this system is sustainable. Without Universal Service, telemedicine would not be a reality for patients and health care providers in this very remote region of California. Since 1999, the ten sites participating in our Universal Service program have conducted 110 clinical consultations and over 449 medical education events.

The Universal Service program has been essential for the growth and development of telemedicine services in our region of California. While it has certainly not reached its potential in terms of numbers of rural communities served, it has been a vital and necessary resource for the health care providers participating in our network. Our regional telemedicine network is a Universal Service success story, but we recognize that the limitations and hurdles that exist to access this resource are very real barriers for other rural health organizations. We applaud the FCC for recognizing that the program has not reached its potential and appreciate the opportunity to provide comments on the proposed rulemaking based on our extensive experience with this program since its inception.

SUMMARY OF COMMENTS AND RECOMMENDATIONS

NSRHN has carefully reviewed the proposed rulemaking and have prepared detailed comments for the Commission's consideration. In preparing these comments, we have considered our own experience with the program, and have also evaluated the proposed rulemaking in light of the overall goal of the program: to enhance access to advanced telecommunications and information services for rural health providers. From our perspective, the most critical resource lacking in rural communities is sufficient telecommunications infrastructure to connect rural health providers to broadband networks in an affordable way. Until the issue of infrastructure is addressed in meaningful ways, rural communities in America will continue to be victims of the "digital divide". Thus, our

comments are designed to ensure that Universal Service achieves a goal of encouraging investment in infrastructure by both the public and private sector.

The remainder of this documents presents detailed comments and recommendations covering the following areas:

1. **Eligibility for Universal Service Support** – We recommend that the FCC recognize the difference between an entity and the services it provides. If an entity has been determined to be eligible under the FCC criteria, then any health-related service that the entity provides should be an allowable service. This will allow eligible entities that provide services such as long-term care, emergency services or home health , to use Universal Service support for these services.
2. **Definition of "rural" -** To ensure that the broadest numbers of rural providers are able to participate in the program, we recommend that the FCC explicitly define "rural" as a "non-urbanized area as defined by the Bureau of the Census."
3. **Calculation of Discounted Services –** We support replacing the Maximum Allowable Distance with a standard that is realistic and easy to administer. Using the distance from the rural health care provider to the furthest border of the state allows rural providers to achieve the maximum benefit from the program. We also support the idea of using any urban area in a state as the comparison benchmark to determine difference in urban/rural costs. Finally, we recommend that the FCC consider both bandwidth AND functionality when determining the difference in urban and rural telecommunication costs.
4. **Streamlining the Application Process –** We recommend that the FCC mandate timelines for responses for the telecommunications carriers and mandate that telcos bill rural health providers for covered services at the lower "urban rate" while the approval process is taking place. We also recommend that the FCC develop a 2-step process that 1) Establishes eligibility and 2) Requests support for specific services.

5. **Competitive Bidding –** We support the current system of competitive bidding. However, we are concerned about language in the proposed rulemaking that seems to limit the criteria for selection of a telco carrier as a cost-issue alone. There are other factors such as functionality, quality of service, technical support, and future growth opportunities that must be taken into account when selecting a telco vendor.
6. **Support for Internet Use –** We support the use of Universal Service to pay for the cost of connecting to the Internet only when there is a rural/urban difference. We do not support the use of Universal Service funds to pay for monthly Internet service fees for eligible providers because this does not help achieve the goal of infrastructure investment into rural communities.
7. **Telecommunications Partnerships –** We strongly support the development of partnerships between schools, libraries, and rural health organizations, and recommend that the FCC consider allowing far broader partnerships than outlined in the proposed rulemaking.
8. **Fraud and Abuse –** We recommend that the FCC allow a 3-5% variation or "audit exception" in the actual support paid to rural health providers. This will allow for the fluctuation of actual costs charged by the telcos to the rural health providers, either up or down, during the funding year.

ELIGIBLTY FOR UNIVERSAL SERVICE SUPPORT

In defining eligibility for Universal Service support, the FCC appears to confuse the difference between eligible entities and the services that they provide. While it is preferable to expand the list of eligible entities to be more inclusive (see below), it is also vital that the FCC allow eligible entities to use universal service to support **ALL** of the health services that they offer. For example, if an otherwise eligible rural hospital operates a skilled-nursing facility in a community 10 miles from the hospital, then both the hospital and the skilled-nursing facility should receive support for services.

Why? Because the hospital meets the criteria for eligibility as the entity, and the skilled nursing facility is a service operated by the hospital. To meet the needs of their communities, rural health providers offer a variety of services that are unique to their service area. All of the health-related services provided by eligible entities should be able to receive universal service support, regardless of their physical proximity to the entity's main office.

A more expansive change to the regulations would be use the list of eligible entities included in the Act as a starting point, not a limiting factor. One of the most frustrating aspects of the rural health program is the limitation imposed by the program on the type of rural health care providers that are eligible for support. Health care resources in rural communities are so few and far between that the goal of the Universal Service program should be to be as inclusive as possible. In fact, Section 265(h)(1)(A) of the Act acknowledges this by requiring telco carriers to provide discounted telecommunications service "to any public or non-profit health care provider that serves persons who reside in rural areas in that state." Unfortunately, the definition rural health provider listed in the Act is unnecessarily limiting and leaves out important entities in rural communities who provide health care services, including long-term care facilities, emergency service providers, hospice, home health entities, and others. The FCC has taken the position that if a rural health entity is not explicitly listed in the Act, they are not eligible for services. The FCC should explore whether there is any leeway in using this list as a suggestive list, rather than as an exhaustive list.

DEFINITION OF RURAL

We recommend that the FCC use the definition of rural that is used by the Bureau of the Census, which defines rural as a non-urbanized area. Under the current guidelines, the FCC defines rural as "non-metropolitan statistical area", and then applies Goldsmith modifications to include rural areas that do not meet the non-MSA definition. There are two problems with this definition. First, the Office of Rural Health Policy, which developed the Goldsmith modifications, is developing a new

definition of rural that does not incorporate Goldsmith. Thus, the Goldsmith standards will be eliminated and it is unclear what will replace it. A second problem, that is particularly acute in California, is that "non-MSA' is a county-level definition. Many urban counties in California have significant rural areas that are not counted when using the non-MSA definition. Unlike the rest of the nation, counties in California are geographically large – San Bernardino County is the largest county in the U.S., covering over 20,000 square miles. Under the "non-MSA" definition, San Bernardino, and many other California counties would not qualify for Universal Service support, yet these counties have significant number of rural communities.

The definition of rural we are recommending is already being used by two other federal programs – the rural hospital swing bed program and the rural health clinic program. A more inclusive definition of rural will ensure that the broadest number of rural health providers will be able to receive support from Universal Service – assuming that they meet additional eligibility requirements as well.

CALCULATION OF DISCOUNTED SERVICES

Our comments regarding the calculation of discounted services will address the following three areas: Interpretation of Similar Services, Urban Areas, and Maximum Allowable Distance.

1. **Similar Services.** When making comparisons between "similar services", it is critical that the FCC consider both bandwidth AND functionality to determine whether services are similar or not. In our region of California, ISDN services were not installed by the telco and the telco had no intention of installing ISDN, preferring to make investment in DSL technology instead. As a result of this decision by the telco, we had to create a complex network of T-1 and PRI lines to bring in the "equivalent" of ISDN to our ten providers and

our level of Universal Service support is based on the equivalent cost of ISDN in the closest urban area.

What is important about our situation (and many others), is that it is not just the 384-kbps of bandwidth provided by the T-1 lines that allows us to conduct two-way video conferencing, but the other functional aspects of ISDN that make it the preferred technology for affordable, fully-switchable two-way video conferencing. From a functionality standpoint, DSL, while it may provide even more bandwidth that ISDN, does not provide the full functionality needed for two-way, real-time video conferencing. However, if we were looking for affordable high-speed connections to the Internet, then DSL might be both a cost-effective and functional equivalent to an ISDN line. Thus, it is important to consider both bandwidth and functionality when comparing "similar services" between rural and urban areas.

2. **Urban Areas.** We support the Commission's suggestion that the rules be altered to allow comparison for telecommunications rates between rural areas and any urban area in the state. In our region, the closest urban area to our health care providers is Redding, a city of 65,000. However, this makes it one of California's smallest urban areas, and is not a good benchmark for services that are available in Sacramento, San Francisco, or Los Angeles.
3. **Maximum Allowable Distance.** We support the elimination or modification of the MAD because it is difficult to calculate and has been an artificial barrier to the full implementation of Universal Service for many communities. The biggest problem with the MAD is that it assumes that the rural health care provider will connect with specialists in the nearest urban area. However, for many of the more remote rural providers, the nearest urban area does not have the necessary compliment of specialists to provide telemedicine services. For example, Redding, California is the closest tertiary care center for many of

our rural health providers. However, Redding does not support a full range of tertiary services, such as child psychiatry, pediatric neurology, or immunology. These are available only in Sacramento, an additional 150 miles south of Redding.

However, we are concerned that any replacement calculation be realistic, and easy to administer. We support the idea of determining the distance from the rural health care provider to the furthest point of the state's border. We do not support the idea of limiting discounts based on the distance to the nearest point of tertiary care for two reasons. First, not all tertiary care services are offered in all urban communities, as discussed above. Secondly, for many of our border communities, this tertiary care point may be out of the state.

STREAMLINING THE APPLICATION PROCESS

We recommend that the FCC make the following changes in the application process:

a. **Establish a 2-step eligibility and service request process.** We believe it is important to have entities establish their eligibility as a separate process from requesting services. This is because many rural health providers may, in fact, be eligible for Universal Service, but may not need the type of services covered by the program. For example, our network provides continuing medical education for rural providers who have established their eligibility to use the PRI lines covered by universal service, but these providers themselves do not need Universal Service support. Once an entity has established eligibility, there should be a simple on-line certification verifying information on an annual basis.

b. **Mandate Telco Response Timelines.** The biggest problem with requesting services has been working with the telcos. Often, they have taken 3-6 months to respond to our request for assistance in completing the necessary paperwork. We recommend that the

FCC establish mandatory timeframes for telco response (30-60 days) and provide enforceable penalties for non-compliance.

c. **Allow multi-year service requests or automatic annual renewal.** We recommend that the FCC establish multi-year application for services, or allow health care providers and telcos to certify renewal of existing systems to eliminate the burden of redundant paperwork year after year, when services are unchanged.

d. **Eliminate "up-front" billing.** One of the most burdensome aspects of the Universal Service program is the requirement that rural health care providers pay for the services they are receiving while the cumbersome and lengthy Universal Service program grinds along. For the first two years of the program, our small, non-profit organization had to pay $11,000 in telco charges per month while we waited for USAC approval of our applications. While the approval process has moved more quickly this past year, it is still a burden to pay these large bills every month. The requirement that the rural provider "front-load" the costs of the service is a real barrier to participation in this program. We recommend that the telcos be mandated to bill for services at the estimated lower "urban" rate once they have received a request for service. This will ensure that they are motivated to complete the necessary paperwork, and will also eliminate the financial burden of paying for services on those organizations that are least able to afford it.

COMPETITIVE BIDDING

We support the current system of competitive bidding. For the first time this year, we received enquiries from telcos outside of our service area to provide us with necessary services for next year. However, we are concerned that the requirement to select a carrier based only on cost is too limiting. Many factors must be considered when selecting a telco vendor, particularly for complex systems like

ours. In addition to cost, we must consider the quality of service we are being promised; i.e. will the system operate reliably and consistently at the bandwidth that we require. We also must consider technical support – will the vendor be able to address technical problems in a timely and efficient manner? Finally, we have to consider future growth and expansion of our network. A vendor may be able to provide us with cost-effective services, but only for a limited range of services. We recommend that the FCC allow health care providers to select the telco carrier that best meets their needs based on a variety of factors including price, functionality, quality of service, technical support, and future expansion.

SUPPORT FOR INTERNET USE

We support the use of Universal Service to pay for the cost of connecting to the Internet only when there is a rural/urban difference. We do not support the use of Universal Service funds to pay for any form of Internet access because this does not help achieve the goal of infrastructure investment into rural communities. Paying for Internet access when there is no cost differential could significantly deplete the rural health care fund, thus reducing funds available to address infrastructure issues. We believe that one of the main reasons that Internet services are more expensive in rural areas is because of the lack of broadband infrastructure available to support high-speed connections. Thus, rural health providers must make long-distance phone calls to get to Internet Service Providers (ISP) and this is currently supported by Universal Service. However, if infrastructure such as DSL is available to connect rural communities to broadband services, there should be no difference in the rates, and there should be no support for rural providers. If, however, fees for DSL are higher for the rural health providers, then Universal Service should be used to pay the difference. We also recommend that the FCC develop a mechanism to obtain payments from ISPs into the Rural Health Care fund for Universal Service.

TELECOMMUNICATIONS PARTNERSHIPS

Partnerships and collaborations are one of the best ways to develop enough market share to encourage investments by telcos into rural communities. We recommend that that FCC provide incentives for the development of partnerships and linkage mechanisms in rural and frontier communities in which separate T-1 circuits have been separately installed to libraries, schools, and health care providers in a single community. There should be incentives for cost sharing when communities are small enough to share a line and its costs, and where geographic realities make line sharing possible. For example, during the planning stages of our telemedicine network, we explored joint use of our T-1/PRI lines with schools and libraries who had the same needs as health care providers for affordable access to broadband communications. Unfortunately, we learned that even though we would be developing a more cost-effective system for all three types of users, Universal Service would take away support from health care, rather than provide incentives for the efficient use of bandwidth. So, instead, all three groups are developing separate systems, at greater expense, then would be possible if Universal Service allowed for greater flexibility to design efficient telecommunications systems.

FRAUD AND ABUSE

We recommend that the FCC allow a 3-5% variation or "audit exception" in the actual support paid to rural health providers. This will allow for the fluctuation of actual costs charged by the telcos to the rural health providers, either up or down, during the funding year. In our participation in the Universal Service program over the past three years, we have noted that the bills we receive from the telcos are not static. While rates we have negotiated by contract remain stable, tariff rates that are subject to approval by the California Public Utilities Commission are adjusted frequently during the year. The adjustments are usually minor, but they cause our rates to up and down. Under strict

interpretation of the Universal Service regulations, we should be submitting new forms for every rate adjustment, which is just not practical. We have no control over what the telco bills for service. In order to reflect the reality of tariff services, we recommend that the FCC allow a 3-5% "audit exception" to allow for fluctuating cost of services, both up and down.

CONCLUSION

The digital divide is real in rural America and we appreciate the efforts of Congress and the FCC to provide a more equitable playing field for rural heath providers. Information is becoming one of the most important tools in the health care providers "black bag". Yet the ability to obtain information quickly and affordably is becoming more difficult for rural health providers. We appreciate the effort that the FCC has made to date on the implementation of Universal Service and look forward to an improved and expanded program under new regulations.

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